SUGGESTED FORM

Mental Retardation Community Medicaid Services

_____ NEW FOR CSP YEAR

___ REVISION FOR CSP YEAR

INDIVIDUAL SERVICE PLAN

Indicate Service: ____ Agency-Directed Personal Assistance Services
____ Agency-Directed Respite Services

ESTIMATED DURATION:_____

Individual: _____ Medicaid Number:_____

Code:_____Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Designated Backup (for Pers. Assist.):_____Telephone:_____

Start Date:_____ End Date:_____ Quarterly Review Dates: _____ _____ _____ _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME:

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual: _____ Service: _____ Start Date: _____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

SUGGESTED FORM

Individual: _____ Service: _____ Start Date_____

TOTAL HOURS PER WEEK

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: Respite Services are limited to 720 hours per year. This includes Agency-Directed & Consumer-Directed combination situations.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*